US Decisions Inc.

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DATE NOTICE SENT TO ALL PARTIES: Dec/01/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Transforaminal ESI at L3-L4 bilaterally

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Orthopedic Surgeon (Joint)

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. it is the opinion of the reviewer that the request for transforaminal epidural steroid injection at L3-L4 bilaterally is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is XX/XX/XX. On this date the patient was on the top of an X power washing the X when he fell back on his low back. Note dated 05/27/15 indicates that the patient is approximately XX status post bilateral laminectomy/discectomy at L3-4. He has not been seen since xxxx xxxx. He is now three months out from an ACDF. Note dated 08/05/15 indicates that he has had about 40 hours of physical therapy since his surgery with only mild relief. He continues to do stretches and exercises at home. MRI of the lumbar spine dated 08/24/15 revealed at L3-4, L3 is minimally shifted and rotated to the left. The thecal sac is minimally flattened by the misalignment plus diffuse disc bulging, but decompressed with bilateral laminotomies and a right medial facetectomy. The foramina are minimally narrowed by the misalignment plus partial disc collapse and endplate osteophytes. The lateral epidural spaces and right foramen contain enhancing tissue but no convincing evidence of a focal disc fragment. Office visit note dated 10/02/15 indicates that the patient complains of back and bilateral leg pain. On physical examination gait and station are normal. Strength is 5/5 in the bilateral lower extremities. Sensation is intact throughout. Straight leg raising is negative bilaterally.

The initial request for transforaminal epidural steroid injection at L3 L4 bilaterally was non-certified on 10/15/15 noting that there is no clinical support for the TFE as the neuro exam is completely normal and there is no evidence of radiculopathy on the exam to support the request as per ODG criteria. The denial was upheld on appeal dated 11/06/15 noting that no new information was provided for this review. On physical examination there was evidence of paraspinous muscle pain, tenderness to palpation of the lumbar spine, and increased pain with flexion and extension. However, there was no objective evidence of radiculopathy documented on physical examination or in corroboration with imaging results.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries in xxxxxx and has been treated with surgical intervention, physical therapy and medication management. The patient has been recommended to undergo a lumbar transforaminal epidural steroid injection at L3-4 bilaterally. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The patient's physical examination fails to establish the presence of active radiculopathy with 5/5 strength, intact sensation and negative straight leg raising bilaterally. There is no rationale provided to support an epidural steroid injection in the absence of clinical signs of radiculopathy. As such, it is the opinion of the reviewer that the request for transforaminal epidural steroid injection at L3-L4 bilaterally is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)